Compassion Center
2055 W. 12th Avenue. Eugene OR 97402 Phone (541) 484-6558 Fax (541) 484-0891

CLINIC REGISTRATION INSTRUCTIONS

Please read this important information carefully

***All patients must complete a registration packet.**

These forms are part of your permanent patient record with Compassion Center Clinic. Please read this registration thoroughly and be sure to answer each question as completely and as accurately as possible. Please include a method of payment with completed registration. We accept cash, checks, money orders, and credit cards. Make out all checks and money orders to "Compassion Center".

STEPS TO COMPLETE YOUR REGISTRATION PACKET:

1. Complete and sign the **Renewal Clinic Registration form**.
2. Complete, date, initial and sign the **Authorization for Release of Medical Records form** included in this packet unless you are bringing records in. For returning patients, we require at least one medical record from **within the past year** documenting your qualifying condition. New patients, please provide at least two years of medical history.
   ***VETERANS**: Fill out a **VA Authorization for Release of Medical Records,** which can be found at our website, or requested at the front desk.
3. Turn your registration packet in to Compassion Center.
4. The medical records staff at Compassion Center will fax or mail the Authorization for Release of Medical Records form to the doctor or medical facility you have indicated. Once we have received and reviewed your medical records, we will call to schedule an appointment for the earliest available clinic. It may take 2-4 weeks for your doctor to send records to us.

   Please review our **Privacy Policy** (available at our website and office).

FEES FOR ALL PATIENTS:

- **$25 registration fee**: must be paid before registration can be processed.
- **$150 Doctor Appointment and Physical Exam**: must be paid before or on the day of your appointment.

All fees are non-refundable.
Make checks/money orders payable to Compassion Center.
We charge $35 for returned checks. Compassion Center fees are subject to periodic review and change.
We charge $30 for a missed appointment due to no-show or less than 24-hour notice

NOTE: Registering with Compassion Center as a patient is not the same as registering or renewing with the State of Oregon for the OMMP. The state requires an application and payment of a fee for registering with the OMMP. For current information and fees call Oregon Medical Marijuana Program at 971-673-1234.

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RENEWAL CLINIC REGISTRATION

Last Name_____First_____MI_____DOB____/___/_____Phone (____)____---_____

Mailing Address _____ _____
Street Apt# City State Zip

Email_____My OMMP card expiration date:_____/____/_____

Emergency Contact: Name_____Phone (____)____--_____

My qualifying medical condition as I understand it is

_____

_____

My last visit to Compassion Center Clinic was on or about:
___ ____ _____with Dr._____

My condition treatment has changed since my last visit to the Compassion Center: ☐No ☐Yes, and changes in my condition or treatment for my condition include:_____

_____

_____

_____

Treatments, surgery, medication, or alternative care prescribed for my condition: _____

_____

PRESENT MEDICAL CONDITION

Do you use MMJ for another medical condition?☐No ☐Yes
If yes, please describe: _____

_____

Does marijuana reduce your need for prescribed medications?
☐No ☐Yes, prescription name(s) _____

_____

Do you use marijuana to alleviate unwanted side effects of any prescribed medications? ☐ No ☐Yes, please describe:

_____

Have you experienced any unwanted side effects from using marijuana as medicine? ☐ No ☐Yes, please describe:

_____

_____

_____

Medicating with marijuana benefits my medical condition, and I am choosing to use it as a treatment for my condition. I have also had an opportunity to review Compassion Center's Privacy Policy. The information contained in this application is true and accurate to the best of my knowledge.

Patient signature_____Date Signed _____

METHOD OF PAYMENT: VISA MASTERCARD DISCOVER (circle one)

My credit card number is _____-_____-_____-_____ Expiration date _____/_____

Amount paid _____ Signature _____ 3-digit Code # _____

For Staff Use Only

Appointment Date _____

Scheduled by: Initials _____

COPY ID HERE

Date Paid_____ Date Paid_____

Amount $_____ Amount $_____

Receipt #_____ Receipt # _____

Initials _____ Initials_____

Cash/Check/Credit Card Cash/Check/Credit Card

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AUTHORIZATION for RELEASE of MEDICAL RECORDS:

Name of Patient: _____DOB: __ / __ /___

REQUESTING RECORDS FROM:

Physician / Facility: _____

Street Address: _____

Phone: _____ Fax: _____

Please forward these records to:

Compassion Center

2055 W. 12th Ave

Eugene, Oregon 97402

Phone: 541.484.6558 Fax: 541.484.0891

Please MAIL if 10 or more pages *Please FAX if less than 10 page*

I specifically authorize the release of the following records for the purpose of *Continuing Care*:

From period _____ to _____

(BEGIN DATE) ***(END DATE)***

◊ NEW PATIENTS***: Please provide 2yrs of history*** ◊RENEWAL PATIENTS : ***Provide 1yr of history***

If the information to be disclosed contains the types of records or information listed below, additional laws relating to the use and disclosure of that information may apply. I understand and agree that this information will be disclosed if I initial the applicable space next to that type of information.

⇨ _____ Mental Health ⇨ _____Drug/Alcohol ⇨ _____HIV/AIDS ⇨ _____Genetic Testing

I understand that the information used or disclosed pursuant to this authorization may be subject to disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict disclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

Refusal to sign this release will not affect ability to receive health care, services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. To revoke this authorization at any time, submit a written request to:

Compassion Center, 2055 W. 12th Avenue, Eugene OR 97402

The only exception is when action has already been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

My signature below acknowledges that I understand and accept this release of information.

Printed Name: _____

Signature: _____ Date: _____

Compassion Center records are confidential and secure. Compassion Center will not share these or any records with any individual or organization without written permission from the patient.

 Last updated 8/2015 *ROI 2015/MR PACKET*